Baldy (J. M.)

THREE CASES OF APPENDICITIS; OPERATION; RECOVERY.

BY

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OF PHILADELPHIA.

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THREE CASES OF APPENDICITIS; OPERATION; RECOVERY.[1]

BY J. M. BALDY, M.D.,
OF PHILADELPHIA.

ON a number of former occasions I have taken the opportunity to advance the doctrine of early and prompt surgical procedures, where it seemed likely that the surgeon must interfere eventually. In appendicitis (I use the term advisedly and broadly, for I believe it well proven that the vast majority of inflammatory attacks in this region are such) this doctrine of early operative interference is imperative. In the history of surgery the greatest strides in lowering the mortality and insuring the success of any given operation have been made when the point of operating at a time of election has been reached, and that time of election has been an early one, as a rule. And so it is with the disease under consideration. In the course of progress attention was first directed toward the surgical treatment; then it began to be realized that operations,

[1] Read before the Philadelphia County Medical Society, Nov. 13, 1889.

if they were to prove of benefit, must be done, not as a last resort, when the patient was dying and everything else had been tried and found wanting, but within a certain limit of time, from the third to the sixth day, or at such a time when a certain set of symptoms had declared themselves, these symptoms usually meaning the existence of an abscess. As the truth of these teachings began to dawn on operators, successes following operations began to be reported, until now there are quite a large number on record, many of them in our own city.

In spite of the number of cures by operation, the deaths, both following operation and when no operation has been performed, so far outnumber these, as to leave them as a mere spot on the horizon. At nearly the same time two surgeons, Treves and Senn, illustrious representatives of the progressive elements of England and America, publicly urge another step in advance, a most important one, and support their arguments by illustrative cases. The point chiefly advanced by both is, not to await the time when the patient's life is in extreme danger, but where there have been repeated attacks of inflammation in the right iliac fossa, to elect deliberately a time between these attacks when the patient is in good health and well able to stand the slight shock of the operation. Treves reports the case of a man on whom he did this prophylactic operation, in the *Lancet* for February, 1889. His patient had had three attacks of inflammation, at intervals of about three months, each one more severe than the

previous. Treves, finally, to prevent the risks of a fourth attack, opened the abdominal cavity and removed the appendix. This he found tightly bound down with adhesions and under coils of intestine adherent to each other and to the appendix and cæcum. The organ was as thick as a man's thumb and was distended with mucus. It was singularly white in color, a peculiarity I have myself noticed in several cases. Recovery was complete and lasting. In the *Journal of the American Medical Association*, November, 1889, will be found Senn's article. He reports two cases. The first operated upon by himself for five previous attacks of perityphlitis. He found an appendix the size of the thick part of the little finger, but not adherent. On section, after removal, an ulcer one-half inch long by one-quarter inch wide penetrating the mucous membrane of the organ and extending into the muscular tissue, was found. The patient has had no return of the old symptoms. The second case reported by Senn was operated upon by Hoegh, of Minneapolis. There had been at least twelve attacks of inflammation, more or less severe. The abdomen was opened by the advice of Senn, and the appendix, which was adherent, removed. On section, several drops of pus flowed out and two large ulcers penetrating through the mucous membrane were found. Recovery was permanent. Since, and even before, these cases were reported lesser lights were at work, and now there are quite a list of such operations on record. One of these I

saw Dr. Bernardy perform on a girl who had had repeated inflammatory attacks. In this case the appendix itself, after being freed from its adhesions, was allowed to remain, it being considered healthy enough to do no harm. The patient made a complete recovery and has remained cured. I have myself, on three occasions, removed the diseased appendix.

During December, 1887, I was called to see Mrs. E., and found her suffering with an attack of peritonitis. She had been in bed much of the time for five weeks. She gave a history of a number of similar attacks during the past few years. An examination of the pelvis disclosed inflammatory disease, and consequently operation was advised. The operation revealed a double chronic salpingitis with general adhesions. To the right Fallopian tube, the vermiform appendix was adherent throughout its entire length, together with a knuckle of small intestine. The adhesions were freed, and after throwing a ligature around the appendix above the diseased part, it was removed. The surfaces denuded by the freeing of adhesions bled freely, and a few silk stitches were put in to bring the peritoneal edges together. The peritoneum was stitched over the stump. The uterine appendages were also removed. Recovery was complete and uneventful. In this case the disease was evidently dependent on the pelvic inflammation. The appendix was perforated in several places, and the whole organ was enlarged to the thickness of one's little finger, and was cheesy and friable.

In November, 1888, I was asked to see Mrs. M., of Trenton, in consultation. She had a history of

pain in the right iliac fossa for some years. One month before the present illness she had marked symptoms of extra-uterine pregnancy, with rupture. At the time of my seeing her she was bedridden, and dying of sepsis. An operation disclosed the remains of a ruptured left tubal pregnancy, which was in a state of beginning suppuration. In the right iliac fossa was a mass of adherent intestines, containing in their midst a diseased and universally adherent vermiform appendix. The adhesions were freed, and the appendix found to be as thick as the little finger, cheesy and perforated at two points. It was ligated *en masse*, and cut away close up to the cæcum. The peritoneum was not stitched over the stump. The left side of pelvis was cleared of its diseased tube, and the patient after a prolonged sickness made a complete recovery, and remains to this day a perfectly well woman. No cause was found for the diseased appendix.

During January, 1889, I was called to see Mrs. F. She gave a history of repeated attacks of pain in the right iliac fossa. During the attack in question the pain was worse than ever before. No tumor could be detected, but there was great tenderness on deep palpation. A pelvic examination revealed enlarged, prolapsed, and excessively tender ovaries. I operated by a median incision, being uncertain whether the attacks of pain were not due to ovarian disease. The appendix was found universally adherent under a coil of adherent intestines. The adhesions were freed, the appendix ligated *en masse* close up to the cæcum, and cut away. The peritoneum was not stitched over the stump. Like the other two cases, the appendix was found as thick as one's little finger, or thicker, and was ex-

tremely cheesy and friable. No cause was found for the disease. The patient made an uninterrupted recovery, and has since remained well.

In none of these cases was there a mesentery of any length to the appendix.

Here, then, by the prophylatic operation we have a mortality of *nil*. Every case of which I am cognizant has recovered. What a difference between this clean record and that with which we must contrast it! The step will be, no doubt, considered a radical one by many, and there will be raised the usual hue and cry against surgical greed; but until a better record can be shown by any of the older methods, we will proceed on the even tenor of our way, and remove a diseased appendix wherever and whenever it can be found. The world has become reconciled to and looks with complacency on the removal of Fallopian tubes similarly diseased and adherent; and so it will be with the appendix vermiformis. They are even more of a menace to the patient's life than are the cases of salpingitis which we all remove, and the diseases are in many respects similar. It may be argued that these cases were successfully carried through the many former attacks of inflammation, and could be again just as successfully treated without the use of the knife. Granted that they were relieved of former attacks, —but the relief proved in every case to be but temporary; and who is to say where the limit in the number of attacks will be reached, or what one may prove fatal? It certainly is not safe to await pus

formation if we can anticipate it; the operations after pus has appeared show sorry results. It was only last winter that this stage was awaited in the case of a medical student in this city, and the student died.

It will be asked, How can we be certain that the appendix is diseased? To this I can but say that, in my experience, there is no positive, constant sign. The most constant and invariable symptoms that I have observed are pain and tenderness in the right iliac fossa. The symptoms of vomiting, tumor, peculiar drawing up of the knees, etc., are too often absent to be depended upon. If they are present, well and good; they form valuable corroborative signs. But with repeated and persistent attacks of pain and tenderness, of sufficient severity, in the iliac region, nothing else being found to account for them, a diagnosis of pericæcal inflammation is warranted.

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